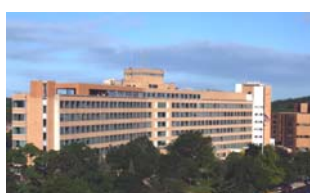


William S. Middleton VA Hospital



*William S. Middleton
Memorial Veterans Hospital
in Madison, Wisconsin*

Pharmacy Residency Programs



PGY2 Ambulatory Care Specialty Residency

The Ambulatory Specialty Residency is designed to develop pharmacy ambulatory practice leaders who have excellent practice skills but also have the ability to direct other clinical staff, develop new programs, and develop policies and procedures that promote rational drug therapy for ambulatory patients. This second year Residency is designed to further develop medication management skills in a multi-disciplinary ambulatory environment. PGY2 Ambulatory Specialty Residents will serve as mentors to first year residents and serve as Chief Residents during the course of the year.

The Residency is affiliated with the University of Wisconsin School of Pharmacy. The clinics provide primary care as well as a wide variety of medical subspecialty care for Veterans throughout Wisconsin and northern Illinois. Pharmacotherapists co-manage patients with Physicians and Nurse Practitioners in a practice that has evolved over 30 years. Residents provide patient care as members of inter-disciplinary teams in these clinics. They assume responsibility for the care of patients. Residents write progress notes for patients they assess and have authority to write prescriptions, order laboratory and other diagnostic tests, consult other services when indicated and develop therapeutic and monitoring plans for patient follow-up. Most patients are managed by outpatient clinic visits but telephone follow-up may also be part of the care provided.

Residents take an active, direct role in patient care in Primary Care teams through the Medication Management Service. Patients are seen in these clinics for a wide variety of medical problems and Residents provide interim care for patients between visits to their primary provider. Residents also provide care in a wide variety of subspecialty clinics including Hypertension, Diabetes, Allergy, Rheumatology, Epilepsy, Osteoporosis and Anticoagulation clinics. Additionally, Residents provide medication management services for the Smoking Cessation program which uses a group session approach to helping patients break their nicotine habit. Electives rotations are available in Psychiatry, Infectious Disease, Hepatitis C, Family Medicine, Dermatology and Women's Health clinics. Residents in the PGY2 Specialty Residency are expected to be more adept at managing complex patients than those completing the first year program.

**Excellence
in
Patient Care
and
Teaching**

Residents also receive teaching experience through assisting with the University of Wisconsin School of Pharmacy Pharmacotherapy Lab. This lab is sequenced with the therapeutics lecture series offered by the school. Residents assist School of Pharmacy faculty in teaching PharmD students on a wide variety of therapeutic topics during the academic year and teach 5-7 weeks during the year. Residents receive academic appointments as clinical instructors for their effort. They also have the opportunity to participate in a teaching certificate program offered by the School. Additional teaching experience is provided by delivery of lectures for pharmacy staff development and participation in a weekly pharmacy journal club where investigational studies related to ambulatory care practice are critiqued and discussed.

In addition to further development of clinical practice skills, the Resident will develop leadership skills. Residents will assist in the development of new policies and procedures needed to carry out the Mission of Pharmacy Service to provide high quality patient care. Graduates of the program learn skills necessary to develop collaborative interdisciplinary practice. They will have the capability to develop new services and take responsibility for planning and management of those services as well as evaluation of the outcomes of new programs

Completion of a project of the Resident's choosing is also required. Residents work with a Pharmacy Staff mentor to plan, carry out and evaluate the results of these projects. They are presented at the Great Lakes Pharmacy Residency Conference in April of each year.

All goals and objectives of the PGY2 Ambulatory Specialty Residency as specified by the American Society of Health System Pharmacists accreditation standards are met by this Residency.

Application Procedure

Applicants must be a graduate of an American Council of Pharmaceutical Education accredited School of Pharmacy with a Pharm.D degree. They must also have completed or currently be enrolled in a first year Residency. We will consider both internal candidates wish to do two years at this institution as well as external candidates. Applicants must have an aptitude and motivation for ambulatory patient care.

Some of the criteria considered in choosing Residents include knowledge of professional practice, communication skills and ability to apply theory to practice, leadership ability, interest in the program, confidence and maturity.

To apply a cover letter stating career goals with an application form (Form 10-2850c) must be completed. In addition, 3 letters of reference and college transcripts are required. An onsite interview is required.

Application deadline is January 31st.

Address inquiries to:

Arthur Schuna

Residency Director

William S. Middleton VA Hospital

2500 Overlook Terrace

Madison, WI 53705

Phone 608-256-1901 extension 11031

Email: aaschuna@wisc.edu



Department of Veterans Affairs

APPLICATION FOR ASSOCIATED HEALTH OCCUPATIONS

SEE LAST PAGE FOR PAPERWORK REDUCTION ACT, PRIVACY ACT AND INFORMATION ABOUT DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER.

INSTRUCTIONS: Please submit this application furnishing all information in sufficient detail to enable the Department of Veterans Affairs to determine your eligibility for appointment in Veterans Health Administration. Type, or print in ink. If additional space is required, please attach a separate sheet and refer to items being answered by number.

1. OCCUPATION FOR WHICH APPLYING A <input type="checkbox"/> CERTIFIED RESPIRATORY THERAPY TECHNICIAN B <input type="checkbox"/> REGISTERED RESPIRATORY THERAPIST C <input type="checkbox"/> LICENSED PHYSICAL THERAPIST D <input type="checkbox"/> LICENSED PRACTICAL/VOCATIONAL NURSE E <input type="checkbox"/> LICENSED PHARMACIST F <input type="checkbox"/> PHYSICIAN ASSISTANT G <input type="checkbox"/> EXPANDED-FUNCTION DENTAL AUXILIARY H <input type="checkbox"/> OCCUPATIONAL THERAPIST <input type="checkbox"/> OTHER (Specify)		
2. NAME (Last, First, Middle)		3. APPLICATION FOR (Check one) <input type="checkbox"/> GENERAL PRACTICE <input type="checkbox"/> SPECIALTY (Identify below)
4. PRESENT ADDRESS (Include ZIP Code)		5. TELEPHONE NUMBER (Include Area Code) 5A. RESIDENCE 5B. BUSINESS
6. DATE OF BIRTH	7. PLACE OF BIRTH	8. SOCIAL SECURITY NUMBER
9A. CITIZENSHIP <input type="checkbox"/> U.S. CITIZEN BY BIRTH <input type="checkbox"/> NATURALIZED U.S. CITIZEN <input type="checkbox"/> NOT A U.S. CITIZEN (Complete item 9B)		9B. COUNTRY OF WHICH YOU ARE A CITIZEN
10A. HAVE YOU EVER FILED APPLICATION FOR APPOINTMENT IN THE VA <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" complete items 10B and 10C)	10B. NAME OF OFFICE WHERE FILED	10C. DATE FILED
11. WHEN MAY INQUIRY BE MADE OF YOUR PRESENT EMPLOYER		12. DATE AVAILABLE FOR EMPLOYMENT

I - ACTIVE MILITARY DUTY

13A. DATE FROM	13B. DATE TO	13C. SERIAL OR SERVICE NO.	13D. BRANCH OF SERVICE	13E. TYPE OF DISCHARGE <input type="checkbox"/> HONORABLE <input type="checkbox"/> OTHER (Explain on separate sheet)
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11 - LICENSURE, DEA CERTIFICATION, REGISTRATION AND CLINICAL PRIVILEGES (As applicable)

14A. LIST ALL STATES/TERRITORIES IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED (If not held now, explain on separate sheet)	14B. LICENSE NO.	14C. CURRENT REGISTRATION (If "NO" explain on separate sheet)			14D. EXPIRATION DATE
		YES	NO	NOT REQUIRED	
15A. ARE YOU FULLY LICENSED IN EVERY STATE IN WHICH YOU RECEIVED A LICENSE (If restricted, limited or probational in any State(s), explain on separate sheet) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT APPLICABLE	15B. DO YOU HAVE PENDING OR HAVE YOU EVER HAD A STATE LICENSE TO PRACTICE REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR ISSUED/PLACED ON A PROBATIONAL STATUS OR VOLUNTARILY RELINQUISHED <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)			15C. HAVE YOU EVER HELD A REGISTRATION TO PRACTICE THAT IS NO LONGER HELD OR CURRENT <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)	
16A. NAME THE CERTIFYING BODY FOR YOUR HEALTH OCCUPATION	16B. DATE OF MOST RECENT REGISTRATION/ CERTIFICATION (Give Month and Year)	16C. WHAT IS YOUR REGISTRY/ CERTIFICATION NUMBER			16D. HAS ACTION EVER BEEN TAKEN AGAINST YOUR CERTIFICATION OR REGISTRATION <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)
17A. DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION, AGENCY OR ORGANIZATION <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" complete item 17B)	17B. NAME OF CURRENT OR MOST RECENT INSTITUTION, AGENCY OR ORGANIZATION WHERE HELD			17C. HAVE ANY OF YOUR STAFF APPOINTMENTS OR CLINICAL PRIVILEGES EVER BEEN DENIED, REVOKED, SUSPENDED, REDUCED, LIMITED, OR VOLUNTARILY RELINQUISHED <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)	

III - THIS SECTION TO BE COMPLETED BY FACILITY DIRECTOR OR DESIGNEE

<div style="display: flex; align-items: center;"> <div style="width: 30px; height: 30px; background-color: black; margin-right: 10px;"></div> <div> CERTIFICATION: I certify that I have verified licensure and registration with State boards, and sighted visa or evidence of citizenship. Board certification has been verified (if appropriate). </div> </div>		
18. EVIDENCE HAS BEEN SIGHTED IN REGARDS TO:		
<input type="checkbox"/> CERTIFICATION OR REGISTRATION <input type="checkbox"/> NATURALIZED CITIZENSHIP <input type="checkbox"/> LICENSURE/REGISTRATION FOR ALL STATES LISTED BY APPLICANT	<input type="checkbox"/> VISA <input type="checkbox"/> CURRENT OR MOST RECENT CLINICAL PRIVILEGES <input type="checkbox"/> NO CURRENT OR PREVIOUS CLINICAL PRIVILEGES	
19A. SIGNATURE OF AUTHORIZED OFFICIAL	19B. TITLE	19C. DATE (MONTH, DAY, YEAR)

IV - LIABILITY INSURANCE (As applicable)

20A. PRESENT LIABILITY INSURANCE CARRIER	20B. DATE COVERAGE BEGAN	20C. NAMES OF PRIOR CARRIERS	20D. DATE OF COVERAGE		21. HAS ANY CARRIER EVER CANCELLED, DENIED OR REFUSED TO RENEW YOUR INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)
			FROM	TO	

V - QUALIFICATIONS**BASIC ALLIED HEALTH EDUCATION** (Continue on separate sheet, if necessary)

22A. NAME OF SCHOOL	22B. ADDRESS (City, State and ZIP Code)	22C. LENGTH OF PROGRAM	22D. DATE COMPLETED	22E. DIPLOMA OR DEGREE RECEIVED

ADDITIONAL EDUCATION (Continue on separate sheet, if necessary)

23A. NAME OF SCHOOL	23B. ADDRESS (City, State and ZIP Code)	23C. MAJOR	23D. DATE COMPLETED	23E. CREDITS	23F. DEGREE

VI - PROFESSIONAL EXPERIENCE

24A. EMPLOYER	24B. ADDRESS (City, State and ZIP Code)	24C. POSITION (Where applicable, also specify whether General Practitioner or Specialist)	26D. FULL- TIME	26E. PART-TIME AVERAGE HOURS PER WEEK	26F. DATES EMPLOYED	
					FROM	TO

VII - GENERAL INFORMATION


25. NAMES UNDER WHICH YOU WERE EMPLOYED, IF DIFFERENT FROM NAME GIVEN IN ITEM 1.

26. LIST ALL PUBLICATIONS, SCIENTIFIC PAPERS, HONORS, AWARDS, RESEARCH GRANTS, FELLOWSHIPS (If additional space is required, attach separate sheet).

VIII - REFERENCES

27. REFERENCES: List at least four persons living in the United States who are not related to you by blood or marriage and who have been in a position to judge your qualifications during the past five years.

27A. NAME	27B. ADDRESS (Number, Street, City, State and ZIP Code)	27C. AREA CODE/PHONE NO.	27D. BUSINESS OR OCCUPATION

REFERENCES (Continued)						
27A. NAME		27B. ADDRESS (Number, Street, City, State and ZIP Code)		27C. AREA CODE/PHONE NO.	27D. BUSINESS OR OCCUPATION	
ITEM NO.	PLACE AN "X" IN APPROPRIATE SPACE. IF "YES" EXPLAIN DETAILS ON SEPARATE SHEET				YES	NO
28.	Do you receive or do you have a pending application for retirement or retainer pay, pension, or other compensation based upon military, Federal civilian, or District of Columbia service?					
29.	Does the Department of Veterans Affairs employ any relative of yours (by blood or marriage)? If "YES" give separately such relative's (1) full name; (2) relationship; (3) VA position and employment location.					
30.	<p>ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN ADMINISTRATIVE OR JUDICIAL PROCEEDINGS IN WHICH MALPRACTICE ON YOUR PART IS OR WAS ALLEGED? (If "YES" give details including name of action or proceedings, date filed, court or reviewing agency, and the status or disposition of case concerning allegations, together with your explanation of the circumstances involved.)</p> <p>(As a provider of health care services, the VA has an obligation to exercise reasonable care in determining that applicants are properly qualified. It is recognized that many allegations of malpractice are proven groundless. Any conclusion concerning your answer as it relates to your qualifications will be made only after a full evaluation of the circumstances involved.)</p>					
<p>NOTE: A conviction or a discharge does not necessarily mean you cannot be appointed. The nature of the conviction or discharge and how long ago it occurred is important. Give all the facts so that a decision can be made. If your answer to question 33, 34 or 35 is "YES" give for each offense: (1) date; (2) charge; (3) place; (4) court and (5) action taken. When answering item 33 or 34, you may omit (1) traffic fines for which you paid a fine of \$100.00 or less; (2) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law; (3) any conviction the record of which has been expunged under Federal or State law; and (4) any conviction set aside under the Federal Youth Corrections Act or similar State authority.</p>						
31.	Within the last five years have you been discharged from any position for any reason?					
32.	Within the last five years have you resigned or retired from a position after being notified you would be disciplined or discharged, or after questions about your clinical competence were raised?					
33.	Have you ever been convicted, forfeited collateral, or are you now under charges for any felony or any firearms or explosives offense against the law? (A felony is defined as any offense punishable by imprisonment for a term exceeding one year, but does not include any offense classified as a misdemeanor under the laws of a State and punishable by a term of imprisonment of two years or less.)					
34.	During the past seven years have you been convicted, imprisoned, on probation or parole, or forfeited collateral, or are you now under charges for any offense against the law not included in 33 above?					
35.	While in the military service were you ever convicted by a general court-martial?					
36.	If you were in the military service in one of these health occupations, did you ever receive a non-judicial punishment (Article 15)?					
37.	<p>Are you delinquent on any Federal debt? (Include delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults on any Federally guaranteed or insured loans such as student and home mortgage loans.)</p> <p>If "Yes" explain on a separate sheet the type, length, and amount of the delinquency or default and steps you are taking to correct errors or repay the debt. Give any identification numbers associated with the debt and the address of the Federal agency involved.</p>					
IX - SIGNATURE OF APPLICANT						
NOTE: A false statement on any part of your application may be grounds for not hiring you, or for terminating you after you begin work. Also, you may be punished by fine or imprisonment (U.S. Code, Title 18, Section 1001).						
<div>  CERTIFICATION: </div> <div> I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF MY STATEMENTS ARE TRUE, CORRECT, COMPLETE, AND MADE IN GOOD FAITH. </div>						
38A. SIGNATURE OF APPLICANT (Sign in dark ink)					38B. DATE (Month, Day, Year)	

AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the Department of Veterans Affairs (VA) to assess and verify my educational background, professional qualifications and suitability for employment, I:

- Authorize the VA to make inquiries concerning such information about me to my previous employer(s), current employer, educational institutions, State licensing boards, professional liability insurance carriers, American Medical Association, other professional organizations and/or persons, agencies, organizations or institutions listed by me as references, and to any other appropriate sources to whom the VA may be referred by those contacted or deemed appropriate;
- Authorize release of such information and copies of related records and/or documents to VA officials;
- Release from liability all those who provide information to the VA in good faith and without malice in response to such inquiries; and
- Authorize the VA to disclose to such persons, employers, institutions, boards or agencies identifying and other information about me to enable the VA to make such inquiries.

SIGNATURE

DATE

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

AUTHORITY: The information requested on the attached application form and Authorization for Release of Information is solicited under Title 38, United States Code, Chapters 73 and 74.

PURPOSES AND USES: The information requested on the application is collected primarily to determine your qualifications and suitability for employment. If you are employed by the VA, the information will be used to make pay and benefit determinations and, as necessary, in personnel administration processes carried out in accordance with established regulations and published notices of systems of records.

ROUTINE USES: Information on the form or the form itself may be released without your prior consent outside the VA to another Federal, State or local agency, to the National Practitioner Data Bank which is administered by the Department of Health and Human Services, to State licensing boards, the American Medical Association, and/or appropriate professional organizations or agencies to assist the VA in determining your suitability for hiring and for employment, to periodically verify, evaluate and update your clinical privileges and licensure status, to report apparent or potential violations of law, to provide statistical data upon proper request, or to provide information to a Congressional office in response to an inquiry made at your request. Such information may also be released without your prior consent to Federal agencies, State licensing boards, or similar boards or entities, in connection with the VA's reporting of information concerning your separation or resignation as a professional staff member under circumstances which raise serious concerns about your professional competence. Information concerning payments related to malpractice claims and adverse actions which affect clinical privileges also may be released to State licensing boards and the National Practitioner Data Bank. The information you supply may be verified through a computer matching program at any time.

EFFECTS OF NON-DISCLOSURE: See statement below concerning disclosure of your social security number. Disclosure of the other information is voluntary; however, failure to provide this information may delay or make impossible the proper application of Civil Service rules and regulations and VA personnel policies and thus may prevent you from obtaining employment, employees benefits, or other entitlements.

INFORMATION REGARDING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER UNDER PUBLIC LAW 93-579 SECTION 7(b)

Disclosure of your SSN (social security number) is mandatory to obtain the employment and related benefits that you are seeking. Solicitation of the SSN is authorized under the provisions of Executive Order 9397, dated November 22, 1943. The SSN is used as an identifier throughout your Federal career from the time of application through retirement. It will be used primarily to identify your records. The SSN also will be used by Federal agencies in connection with lawful requests for information about you from your former employers, educational institutions, and financial or other organizations. The information gathered through the use of the number will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records. The SSN also will be used for the selection of persons to be included in statistical studies of personnel management matters. The use of the SSN is made necessary because of the large number of present and former Federal employees and applicants who have identical names and birth dates, and whose identities can only be distinguished by the SSN.